EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUMBITTED BY PROVIDENCE EVERETT MEDICAL CENTER PROPOSING TO ADD 166 ACUTE CARE BEDS TO ITS EXISTING CAMPUS IN THE CITY OF EVERETT, WITHIN SNOHOMISH COUNTY.

PROJECT DESCRIPTION

Providence Everett Medical Center (PEMC) is a private non-profit hospital located at 1321 Colby Avenue in the city of Everett within Snohomish County. PEMC is licensed by the Washington State Department of Health as an acute care hospital and is also accredited by the Joint Commission on Accreditation of Health care Organizations (JCAHO).

Information available at the applicant's web site indicated that on March 1, 1994, the Providence and General Hospitals merger became effective and the two hospitals became a new entity known as Providence General Medical Center under the sponsorship of the Sisters of Providence Health Systems (PHS). Providence Health Systems operates a variety of healthcare facilities in Alaska, California, Oregon, Montana and Washington[1].

Providence Health and Services was created as new integrated system with the uniting of Providence Health System and Providence Services, effective January 1, 2006. The health care, senior and community services, housing and education facilities of the Sisters of Providence-sponsored ministries now function together under shared leadership serving Washington, Montana, Oregon, California and Alaska. [Source: Past Forward—online newsletter http://www.providence.org/PHS/archives]

Providence General Medical Center in the year 2000 changed its name to Providence Everett Medical Center. PEMC is part of a group of hospitals within the Washington/Montana region of the PHS[2]. PEMC serves patients from Snohomish, Skagit, Whatcom, Island and San Juan counties.
[Source: http://www.providence.org/everett/news/history.htm]

PEMC stated on its web site that there are four medical campuses offering care ranging from support services to healthcare services such as wellness promotion, inpatient acute care, outpatient services and surgery. PEMC is the only hospital in the central Snohomish planning area. The applicant's certificate of need application proposes to add 166 acute care beds to the 362 currently licensed beds located within PEMC facility.

PEMC proposes building a 12-story tower to contain 242 of its currently licensed beds and 166 new beds. The new tower is scheduled to open in November 2010. In addition to the inpatient beds, the 12-story tower will contain a new Emergency Department, Surgery and support services. The tower's top floor will be built as "shell space and core" as parts of the complete build-out. PEMC indicated that the 166 new beds are incrementally scheduled to be licensed within the new tower in three phases.

[1] PEMC—response to screening questions June 8, 2006 attachment # 1.
[2] PEMC—response to screening questions June 8, 2006 attachment # 1.

Phase One

Phase one bed addition starts from the 5th floor of the new Colby Avenue tower in November 2010. During this phase, 106 new acute care beds are added to the existing 362 licensed beds. With this bed addition, PEMC's acute care bed capacity at the Colby Avenue campus will increase to 468 beds [Source: Rebuttal Statement pg 19]

Phase Two

Phase two is slated for completion by adding 30 beds to portions of the shelled in space within the 12th floor and increasing the facility licensed beds to 498. [Source: Rebuttal Statement pg. 19]

Phase Three

Phase three is slated for completion in January 1, 2017 when the last beds are expected to be licensed in the remaining shelled in space on the 12th floor. With completion of phase three the licensed capacity of PEMC beds would be 528 beds. [Source: Rebuttal Statement pg. 19]

The capital expenditure estimated for the tower expansion is $461,009,197, and the cost allocated to the 166 new beds is $ 72,824,543. [Source: Rebuttal Statement pg. 20]. The costs reported for each phase are outlined in Table 1.

Table 1
Cost of Bed Addition by Phase

Phase	**Capital Cost**
106 Bed Addition	$ 59,868,977
30 Bed Addition	$ 6,477,783
30 Bed Addition	$ 6,477,783
Total	$ 72,824,543

APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to Certificate of Need review as the change in bed capacity of an existing health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

APPLICATION CHRONOLOGY

March 8, 2006	Letter of Intent Submitted
April 12, 2006	Application Submitted
April 28, 2006 through August 2, 2006	Department's Pre-Review Activities 1st screening activities and responses 2nd screening activities and responses
August 10, 2006	Department Begins Review of the Application (1) Public comments accepted throughout review
September 18, 2006	Public Hearing Conducted/End of Public Comment
November 17, 2006	Department's Anticipated Decision Date
December 18, 2006	Department Decision Date

AFFECTED PARTIES

The following entities sought and received affected person status under WAC 246-310-010:

- Valley General Hospital located in the City of Monroe within Snohomish County.
- Campaign to Make Healthcare Work located in the City of Everett within Snohomish County

SOURCE INFORMATION REVIEWED

1. Providence Everett Medical Center's Certificate of Need Application received April 12, 2006
2. Providence Everett Medical Center's supplemental information dated July 27, 2006 and October 2, 2006
3. Providence Everett Medical Center's website (http://www.providence.org/everett/)
4. Washington State Department of Ecology; Washington Zip Code Map (http://www.ecy.wa.gov/services/gis/maps/county/zipcode/zipco.htm)
5. Acute Care Bed Methodology extracted from the 1987 State Health Plan
6. Documents and comments received at the September 18, 2006 public hearing
7. Community members' comments
8. Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Office of Hospital and Patient Data Systems
9. Financial feasibility and cost containment evaluation prepared by the Department of Health's Office of Hospital and Patient Data Systems (November, 2006)
10. Historical charity care data obtained from the Department of Health's Office of Hospital and Patient Data Systems (2003, 2004, and 2005 summaries)
11. Population data obtained from the Office Financial Management based on year 2000 census published January 2002.
12. Oregon Department of Human Services (2003-2004 data)
13. Department of Health – Health Care Facility Survey – Quality of Care Data
14. Certificate of Need Historical files

CRITERIA EVALUATION

To obtain Certificate of Need approval, Providence Everett Medical Center must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); and 246-310-240 (cost containment), and portions of the 1987 State Health Plan as it relates to the acute care bed methodology.[3]

CONCLUSIONS:

For the reasons stated in this evaluation, the Certificate of Need application submitted on behalf of Providence Everett Medical Center to add 166 acute care beds to the hospital is not consistent with the Certificate of Need review criteria. However, the addition of 106 beds to Providence Everett Medical Center (phase one) is consistent with those criteria. With this reduction, the project meets the applicable criteria for the project, and a Certificate of Need should be issued for the addition of 106 beds, resulting in a total of 468 acute care beds.

The approved capital expenditure associated with the addition of 106 beds, or phase one of the project, is $59,868,977.

[3] Each criterion contains certain sub-criterion. The following sub-criteria are not discussed in this evaluation because they are not relevant to this project: WAC 246-310-210(3), (4), (5), and (6).

A. Need (WAC 246-310-210)

Based on the source information reviewed, the department determines that the applicant has met the need criteria in WAC 246-310-210.

(1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need.

The determination of numeric need for acute care hospital beds is performed using the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan (SHP). Though the SHP was "sunset" in 1989, the department has concluded that this methodology remains a reliable tool for predicting the baseline need for acute care beds.

The 1987 methodology was a revision of an earlier projection methodology prepared in 1979 and used in the development of subsequent State Health Plans. This methodology was developed as a planning tool for the State Health Coordinating Council (SHCC) to facilitate long-term strategic planning of health care resources. The methodology is a flexible tool, capable of delivering meaningful results for a variety of applications, dependent upon variables such as referral patterns, age-specific needs for services, and the preferences of the users of hospital services, among others.

The 1987 methodology is a twelve-step process of information gathering and mathematical computation. The first four steps develop trend information on hospital utilization. The next six steps calculate baseline non-psychiatric bed need forecasts. The final two steps are intended to determine the total baseline hospital bed need forecasts, including need for short-stay psychiatric services: step 11 projects short-stay psychiatric bed need, and step 12 is the adjustment phase, in which any necessary changes are made to the calculations in the prior steps to reflect conditions which might cause the pure application of the methodology to under- or over-state the need for acute care beds.

The completed methodology is presented as a series of appendices to this evaluation. The methodology presented here incorporates all adjustments that were made following preparation of the methodology. Where necessary, both adjusted and un-adjusted computations are provided. The methodology uses population and healthcare use statistics on several levels: statewide, Health Service Area (HSA) [4], and planning area. The planning area for this evaluation is the Central Snohomish planning area located in HSA 1. State Health Planning and Development Agency documents from 1981 describe the four planning areas in Snohomish County as follows:

"The North Snohomish planning area includes Camano Island (from Island County), Arlington, Stanwood, Darrington and Granite Falls Eastward.
"Central Snohomish planning area includes Everett, Lake Stevens, Marysville and Mukilteo.
"East Snohomish planning area of Snohomish, Monroe, Sultan through to the county line to the East and South.
"Southwest Snohomish planning area includes Lynnwood, Edmonds, Bothell and Mountlake Terrace.

[4] The state is divided into four HSAs by geographic groupings. HSA 1 is composed of Clallam, Island, Jefferson, King, Kitsap, Pierce, San Juan, Skagit, Snohomish, and Whatcom Counties. HSA 2 is composed of Clark, Cowlitz, Grays Harbor, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston, and Wahkiakum counties. HSA 3 is composed of Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Okanogan, and Yakima Counties. HSA 4 is composed of Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Pond Oreille, Spokane, Stevens, Walla Walla, and Whitman counties.

The planning area descriptions above were accompanied by a list of 29 contiguous Snohomish County zip codes. PEMC provided a list of 12 zip codes that it believes currently meet the description of the Central Snohomish planning area.

When preparing acute care bed need projections, the department relies upon population forecasts published by the Washington State Office of Financial Management (OFM). OFM publishes a set of forecasts known as the "intermediate-series" county population projections, based on the 2000 census, developed January 2002[5]. These forecasts are not, however, available for any area smaller than an entire county. As a result, the department generally relies upon sub-county population projections provided by applicants, provided they are obtained from a reliable source. In this application, PEMC provided sub-county population projections developed by Solucient, a recognized source of demographic information.

This portion of the evaluation will describe, in summary, the calculations made at each step and the assumptions and adjustments made in that step. It will also include a review of any deviations related to the assumptions or adjustments made by PEMC in its application of the methodology.

The titles for each step are excerpted from the 1987 SHP.

Step 1: Compile state historical utilization data (i.e., patient days within major service categories) for at least ten years proceeding the base year.

For this step, attached as Appendix 1, the department obtained utilization data for 1996 through 2005 from the Department of Health's Office of Hospital and Patient Data Systems' CHARS (Comprehensive Hospital Abstract Reporting System) database. Total patient days were identified for the Central Snohomish Planning Area, HSA #1, and Washington State as a whole, excluding psychiatric patient days [Major Diagnostic Category (MDC) 19] and normal newborns [Diagnostic Related Group (DRG) 391], according to the county in which care was provided. Normal newborn days (DRG 391) were excluded because the normal newborn patients (babies) do not occupy a licensed acute care bed. The mothers of the normal newborns are included in the patient days (MDC 14 and DRG 370-384). PEMC followed this step as described with no deviations.

Step 2: Subtract psychiatric patient days from each year's historical data.

This step was partially accomplished by limiting the data obtained for Step 1, above. The remaining data still included non-MDC 19 patient days spent at psychiatric hospitals. Patient days at dedicated psychiatric hospitals were identified for each year and subtracted from each year's total patient days. The adjusted patient days are shown in Appendix 2. PEMC followed this step as described with no deviations.

Step 3: For each year, compute the statewide and HSA average use rates.

The average use rate (defined as the number of patient days per 1,000 population) was derived by dividing the total number of patient days in each HSA by that HSA's population and multiplied by 1,000. Using the same process, the average use rate was also determined for the Central Snohomish

[5] Found on the World Wide Web at http://www.ofm.wa.gov/pop/estimates.asp and at http://www.ofm.wa.gov/pop/poptrends/default.asp.

planning area and is attached as Appendix 3. PEMC followed this step as described above with no deviations. However, PEMC also provided a second bed need projection using the Central Snohomish planning area specific trend. This will be discussed in Step 12.

Step 4: Using the ten-year history of use rates, compute the use rate trend line, and its slope, for each HSA and for the state as a whole.

The resulting trend lines from the ten-year history of rates uniformly exhibit an upward slope in all three computations. This conclusion is generally supported by increasing utilization reported by hospitals throughout the state in recent years, and may be indicative of a growing population. More significant than overall population growth is the fact that the state's population is growing older as the number of "baby boomers" (those born from 1946 to 1964) age and begin to demand more health services. Utilization of hospital beds by patients aged 65 and older is significantly higher than bed utilization by younger patients, as demonstrated in subsequent calculations. PEMC followed this step as described with no deviations.

Step 5: Using the latest statewide patient origin study, allocate non-psychiatric patient days reported in hospitals back to the hospital planning areas where the patients live. (The psychiatric patient day data are used separately in the short-stay psychiatric hospital bed need forecasts.)

The previous four steps of the methodology involved data identified by the planning area where care was provided. In order to determine the need for services for residents of a given planning area, patient days must be identified, instead, by the area where the patients live. Step 5, included as Appendix 5, identifies referral patterns in and out of the Central Snohomish planning area and illustrates where residents of the planning area currently receive care. For this calculation, the department separated patient days by age group (0-64 and 65 and older), and subtracted patient days for residents of other states. The department also uses hospital discharge data obtained from the Oregon Department of Human Services to identify patient days for Washington residents obtaining health care in Oregon (the department is not aware of similar data for the state of Idaho). For purposes of this evaluation, the Oregon data for 2003/04 was utilized. As a result, the department determined that there was slightly more in-migration to the Central Snohomish planning area than was indicated by the applicant's calculations.

As has been noted earlier, the original purpose for this methodology was to create comprehensive, statewide bed need forecasts. For this project, the state was broken into two planning areas – Central Snohomish and the state as a whole minus Central Snohomish. Appendix 5 illustrates the age-specific patient days for residents of the Central Snohomish planning area and for the rest of the state, identified here as "WA – CS."

PEMC followed this step as described with no deviations.

Step 6: Compute each hospital planning area's use rate (excluding psychiatric services) for each of the age groups considered (at a minimum, ages 0-64 and 65+).

Appendix 6 illustrates the age-specific use rates for the year 2005, as defined in Step 3, for the Central Snohomish planning area and for the rest of the state. PEMC followed this step as described with no deviations.

Step 7A: Forecast each hospital planning area's use rates for the target year by "trend-adjusting" each age-specific use rate. The use rates are adjusted upward or downward in proportion to the slope of either the statewide ten-year use rate trend or the appropriate health planning region's ten-year use rate trend, whichever trend would result in the smaller adjustment.

As discussed in Step 4, the department used the ten-year use rate trends for 1996-2005 reflect the behavior of Washington residents. The 2005 use rates determined in Step 6 were multiplied by the slopes of both the planning area's ten-year use rate trend line and by the slope of the statewide ten-year use rate trend line for comparison purposes. For the Central Snohomish planning area, the planning area trend is a higher rate of increase (an annual increase of 8.8628) than the statewide rate of increase (an annual increase of 2.956). As directed in Step 7A, the department applied the statewide trend to project future use rates.

PEMC followed the step as described with no modifications.

The methodology is designed to project bed need in a specified "target year." PEMC proposes adding 106 beds by November 2010 for a 468 bed hospital tower. Phase two of the project is scheduled to begin in January 2015 with the addition of 30 beds, and the final 30 beds would be added in January 2017. The Department prepared the bed need methodology to show the effect of implementing the entire project as proposed and detailed in Appendix 10b.

It is the practice of the department to evaluate need for a given project through seven years from the last full year of available CHARS data, 2012 for purposes of this analysis. If the project is phased, another three years following completion of the project is often considered, or 2015. In review of this application, the bed need methodology was continued through 2017 to provide a complete analysis of the 106 bed addition.

For this project, 2010 was used as the sample year for the calculations in Appendix 7 through 9. The department's projections are presented in the summary attached as Appendix 10a -10d of this analysis.

PEMC applied the statewide trend and prepared projections through 2023.

Step 8: Forecast non-psychiatric patient days for each hospital planning area by multiplying the area's trend-adjusted use rates for the age groups by the area's forecasted population (in thousands) in each age group at the target year. Add patient days in each age group to determine total forecasted patient days.

Using the statewide forecasted use rate for the sample year 2010 and the intermediate series population projections prepared by OFM for the state and the planning area, the department's projected patient days for the Central Snohomish planning area residents are illustrated in Appendix 8. As noted in Step 7 above, forecasts have been prepared for a series of years and are presented in summary in Appendix 10a -10d as "Total Central Snohomish Res Days." PEMC followed this step as described with no deviation.

Step 9: Allocate the forecasted non-psychiatric patient days to the planning areas where services are expected to be provided in accordance with (a) the hospital market shares and (b) the percent of out-of-state use of Washington hospitals, both derived from the latest statewide patient origin study.

Using the patient origin study developed for Step 5, Appendix 9 illustrates how the projected patient days for the Central Snohomish planning area and the remainder of the state were allocated from county

residents to the area where care is projected to be delivered in the sample year 2010. The results of these calculations are presented in Appendix 10a -10d as "Total Days in Central Snohomish Hospitals."

PEMC followed this step as described with no deviation

Step 10: Applying weighted average occupancy standards, determine each planning area's non-psychiatric bed need. Calculate the weighted average occupancy standard as described in Hospital Forecasting Standard 11.f. This should be based on the total number of beds in each hospital (Standard 11.b), including any short-stay psychiatric beds in general acute-care hospitals. Psychiatric hospitals with no other services should be excluded from the occupancy calculation.

The number of beds in the planning area was identified in accordance with the SHP standard 12.a. which states:

1. beds which are currently licensed and physically could be set up without significant capital expenditure requiring new state approval;
2. beds which do not physically exist but are authorized unless for some reason it seems certain those beds will never be built;
3. beds which are currently in the license but physically could not be set up (e.g., beds which have been converted to other uses with no realistic chance they could be converted back to beds);
4. Beds which will be eliminated.

SHP determines the number of available beds in each HSA, by including only those beds that meet the definition of #1 and #2 above, plus any CN approved beds. This information was gathered through CN and Facilities and Services Licensing records. There is currently only one acute care hospital in the Central Snohomish planning area—the applicant with 362 beds. [Source: CN and OHCS files]

The weighted occupancy standard for a planning area is defined by the SHP as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area. In previous evaluations, the department determined that the occupancy standards reflected in the 1987 SHP are higher than can be maintained by hospitals under the current models for provision of care. As a result, the department has adjusted the occupancy standards presented in the SHP downward by 5% for all but the smallest hospitals (1 through 49 beds). As a result of this change, the Central Snohomish planning area's weighted occupancy has been determined to be 75%. This is reflected in the line "Wtd Occ Std" in Appendix 10a -10d.

While the methodology states that short-stay psychiatric beds should be included in the above total, the fact that all psychiatric patient days were excluded from the patient days analyzed elsewhere in the methodology makes their inclusion inconsistent with the patient days used to determine need.

PEMC also reduced the weighted occupancy consistent with the reductions outlined by the department, and did not include short stay psychiatric beds within in its calculations.

Step 11: To obtain a bed need forecast for all hospital services, including psychiatric, add the non-psychiatric bed need from step 10 above to the psychiatric inpatient bed need from step 11 of the short-stay psychiatric hospital bed need forecasting method.

The applicant is not proposing to add psychiatric services at the facility. In step 10, the department excluded the short stay psychiatric beds from the bed count total. For these reasons, the department concluded that short-stay psychiatric beds should not be forecast.

PEMC also did not provide short-stay psychiatric bed projections.

Step 12: Determine and carry out any necessary adjustments in population, use rates, market shares, out-of-area use and occupancy rates, following the guidelines in section IV of this Guide.

Within the department's application of the methodology, adjustments have been made where applicable and described above.

Appendix 10a calculates the planning area bed need without the project. Appendix 10b calculates the planning area bed need with the project. A summary of those appendices is shown below.

Table 2
Appendix 10A and 10B – Need Summary

	2008	***2009***	***2010***	***2011***	***2012***	***2013***	***2014***	***2015***	***2016***	***2017***
Planning Area # of beds	362	362	362	362	362	362	362	362	362	362
Need/Surplus - Without Project (Appendix 10a)	3	15	27	42	57	73	89	106	124	142
Planning Area # of beds	362	362	468	468	468	468	468	498	498	528
Need/Surplus - With Project (Appendix 10b)	3	15	-79	-64	-49	-33	-17	-30	-12	-24

As shown in Table 2 above, Appendix 10a projects a planning area need for 3 beds in 2008 increasing to 57 beds in 2012 and 106 beds in 2015.

Appendix 10b projects a need for 3 beds in 2008. In 2010, when the 106 Phase one beds are added, there is a surplus of 79 beds in the planning area. The surplus continues through at least 2017 when Phase three is complete.

In summary, if this project is not approved, the planning area is projected to have a need for 3 beds beginning in year 2008, which increases to 106 beds by the end of year 2015. If this project is approved as submitted, the planning area is projected to have a surplus of 79 beds in year 2010. If this project is fully implemented as proposed, the planning area would be over-bedded for more than 10 years from the end of Phase one.

In rebuttal comments, the applicant provided two methodologies. One that mirrored the department's described. In 2010, projects a need for 26 beds. The department projected a need for 27. The similarity continues out to 2017 where PEMC projects a need for 141 beds to the program's 142. [Source: Rebuttal Statement, Appendix. 2]

PEMC also provided a second forecast based on the Central Snohomish planning area use rate trend. Using this trend, the projected need increases considerably faster than the method previously described. For example, the bed need in 2017 using the Central Snohomish trend is for 202 beds. This is 61 more beds that either the applicant's initial projection or the departments.

The applicant makes an appeal to have the department extend the forecast horizon beyond the traditional period to adhere to RCW 70.38.015 citing, "…that the development of health services and resources, including the construction, modernization, and conversion of health facilities, should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation". As this project is outlined, the additional beds is projected to be a supplemental piece to an overall expansion of services for the hospital. [Source: Rebuttal Statement, pg. 16]

The department practice, as outlined in the State Health Plan, is to forecast seven years. Further, when a difference exists between the statewide, HSA and service area slope trends, the more conservative of the three is chosen for projection of need. When the bed need is reviewed with the additional 106 beds according to the statewide trend for seven years from the target year, or 2012, the Central Snohomish planning area is projected to have an excess of 49 beds. This excess continues up to and through the year 2015, a full 5 years after completion of Phase one, as shown below and included as Appendix 10c.

Table 3
Appendix 10c – 106 Bed Addition Forecast

	2008	***2009***	***2010***	***2011***	***2012***	***2013***	***2014***	***2015***	***2016***	***2017***
Planning Area # of beds	362	362	468	468	468	468	468	468	468	468
Need/Surplus - Phase one only	3	15	-79	-64	-49	-33	-17	0	18	36

In addition to the numeric methodology above, the department must also determine whether existing providers are available and accessible in the planning area. The applicant is the only provider of acute care in the Central Snohomish planning area and has experienced an increase in their ED admissions. The additional capacity for ED operations appears to be a practical component in the plans for this project.

With the inclusion of increased Emergency Department space, Surgery services and hospital support capacity, the proposed increased bed capacity is reported to be 15.8 % of the overall cost of the expansion.[6] With the allocated costs representing a minimal cost center of the overall project, the department finds it difficult to conclude that a reduced approval of the requested beds would have an adverse effect on the health planning or a reduction in tertiary care services [Source: Rebuttal Statement, pg. 3].

The department notes that PEMC's patient days have grown steadily over the ten year period included in this analysis. Positions pointed to in rebuttal statements addressing unusually high growth in the region warrants consideration in the use of the slope trend for the Central Snohomish service area. [pg.9] Steps 7 and 8 in the bed need methodology assume a continuation of the current referral patterns. There is no

[6] According to capital expenditure figures for the entire 166 bed expansion

indication that Central Snohomish will be taking a disproportional degree of service obligations if the growth materializes as reported.

Based on the numeric need methodologies prepared by both the applicant and the department, consistent with the guidance of the methodology, PEMC's proposal to add 166 acute care beds is not supported. The methodology does support the approval of 106 new acute care beds as outlined in Phase one of the project. Therefore, based on the above evaluation, PEMC's to proposed Phase one of this project, to add 106 acute care hospital beds, is consistent with this sub-criterion.

(2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.

The department uses a facility's Medicare certification as the measure to determine whether elderly patients would have access to the proposed services. PEMC is a participant in the Medicare program. [Source: Application pg 3] Medicare patients are expected to continue to have access to care if this project is approved. [Source: Application pg. 36]

The department uses a facility's Medicaid eligibility or contracting with Medicaid as the measure to make the determination of whether low income residents would have access to the proposed services. PEMC is a participant in the Medicaid program. [Source: Application pg 3] Medicare patients are expected to continue to have access to care if this project is approved. [Source: Application pg. 36]

PEMC states that, as part of the Providence Health System, their mission is to provide compassionate care to all people in need. This includes a special concern for those who are poor and vulnerable. [Source: Application pg 17] The admission policies provided states "we make services available to all persons residing in the facility service area without discrimination on the ground of race, color, natural origin, creed, or any other ground unrelated to an individual's need for service or the availability of the needed services in the facility". [Source: Application Appendix 8, pg 4] The charity care policies provided in the application indicate that all PHS facilities accept patients for treatment and care regardless of the patient's ability to pay.

For charity care reporting purposes, the Department of Health's Office of Hospital and Patient Data Systems (OHPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. PEMC is located in Snohomish County within the Puget Sound Region. According to 2003-2005 charity care data obtained from OHPDS, the three-year average for the Puget Sound Region is 1.64% for gross revenue and 3.46% for adjusted revenue. [Source: OHPDS 2003-2005 charity care summaries] PEMC reported to OHPDS for 2003-2005 an average of 2.71% of gross revenue and 5.84% of adjusted revenue. Both values exceed the regional average and the average of the other three hospitals serving Snohomish County.[7]

Based on the above information, the department concludes that the applicant has documented that residents of the service area currently have access to the health services at PEMC. Further, the department concludes patients are expected to continue to have access to the health services at PEMC. This sub-criterion is met.

[7] Hospitals cited include Cascade Valley, Valley General and Stevens Memorial

B. Financial Feasibility (WAC 246-310-220)
Based on the source information reviewed, the department determines that the applicant has met the financial feasibility criteria in WAC 246-310-220.

(1) The immediate and long-range capital and operating costs of the project can be met.

To assist the department in its evaluation of this sub-criterion, Office of Hospital and Patient Data Systems (OHPDS) provides a summary of the short and long-term financial feasibility of the project, which includes a financial ratio analysis. The analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios utilized are **1)** long-term debt to equity ratio; **2)** current assets to current liabilities ratio; **3)** assets financed by liabilities ratio; **4)** total operating expense to total operating revenue ratio; and **5)** debt service coverage ratio. If a project's ratios are within the expected value range, the project can be expected to be financially feasible.

Providence Everett Medical Center capital expenditure is projected to be $461,009,197 while the CN portion is 72,824,543. The financing of the project is summarized by OHPDS in this table.

Table 4
Capital Expenditures

Providence Everett New Tower	Cash Reserves	Bond	Total
Certificate of Need Portion	41,428,943	31,395,600	72,824,543
Rest of Project	245,160,254	143,024,400	388,184,654
Total Project	286,589,197	174,420,000	461,009,197

After reviewing this information, OHPDS goes on to state:
"Even though the official applicant for the Certificate of Need is Providence Everett Medical Center, the capital cost of the project is more than the 2005 fiscal year end total assets of the hospital. The parent corporation, Providence Health & Services which is much larger does have the financial strength to directly finance the cash portion of this project". [Source: OHPDS Analysis, pg. 2]

Providence Health & Services will also be the holder of the bond. Below is balance sheet data from the application and other sources.

Table 5
Balance Sheet Summary

Providence Everett Fiscal Year End 2005 in 000's

Assets		Liabilities	
Current	70,333	Current	40,587
Board Designated	14,038	Long Term Debt	121,363
Property/Plant/Equipment	161,629	Other	-
Other	15,414	Equity	99,464
Total	261,414	Total	261,414

Fiscal Year End Financial and Utilization Report to WA ST Dept. of Health

Providence Everett Fiscal Year End 2014 in 000's

Assets		Liabilities	
Current	305,684	Current	44,104
Board Designated	13,758	Long Term Debt	216,717
Property/Plant/Equipment	546,954	Other	8,198
Other	18,267	Equity	615,644
Total	884,663	Total	884,663

from CN application for 166 new licensed beds - end of 3rd yr after 1st phase

Providence Everett Fiscal Year End 2023 in 000's

Assets		Liabilities	
Current	810,735	Current	50,979
Board Designated	13,758	Long Term Debt	86,704
Property/Plant/Equipment	358,564	Other	10,697
Other	23,834	Equity	1,058,513
Total	1,206,891	Total	1,206,893

from CN application for 166 new licensed beds

Providence Health & Service September 2006 in 000's

Assets		Liabilities	
Current	1,348,533	Current	832,644
Board Designated	2,369,190	Long Term Debt	1,437,533
Property/Plant/Equipment	2,815,328	Other	524,972
Other	259,889	Equity	3,997,791
Total	6,792,940	Total	6,792,940

*the data is from a report on the Providence Health & Services website

"Providence Everett Medical Center will use reserves of Providence Health and Services and long-term debt acquired by Providence Health and Services for the costs of the project. Reserves are accumulated mainly from prior year profits or prior debt acquisition. The long-term debt has not been acquired and when it is, the hospital will have financial performance obligations to meet or risk certain penalties. The applicant indicates they will use the Washington State Health Care Facilities Authority process to provide the bond. [Source: OHPDS, Analysis pg. 3]

In the tables below, OHPDS shows percentages of the various expenditures compared to various assets both by the latest Providence Everett Medical Center Balance sheet and the latest un-audited financial statements from the parent Providence Health and Services. The data shows that Providence Health and Services does have the liquid assets to finance the cash portion of the project.

Table 6
Expenditure / Asset Comparison

Providence Everett Medical Center 2005 Year End Financial and Utilization Report - 166 Beds

		CN Project Cash Reserves Portion	Total CN Portion	Total Project Cash Reserves Portion	Total Project
	in 000's				
Project Dollars		41,429	72,824	286,589	461,009
Board Designated Assets	14,038	295.12%	518.76%	2041.52%	3284.01%
Equity	99,464	41.65%	73.22%	288.13%	463.49%
Total Assets	261,414	15.85%	27.86%	109.63%	176.35%

Fiscal Year End Financial and Utilization Report to WA ST Dept. of Health and the application

Providence Health & Service September 2006 Unadited Financial Report* - 166 Beds

		CN Project Cash Reserves Portion	Total CN Portion	Total Project Cash Reserves Portion	Total Project
	in 000's				
Project Dollars		41,429	72,824	286,589	461,009
Board Designated Assets	1,989,671	2.08%	3.66%	14.40%	23.17%
Equity	3,997,791	1.04%	1.82%	7.17%	11.53%
Total Assets	6,792,940	0.61%	1.07%	4.22%	6.79%

*the data is from a report on the Providence Health & Services website and the application

Providence Health & Service September 2006 Unadited Financial Report* - 106 Beds

		CN Project Cash Reserves Portion	106 Bed Portion	Total Project Cash Reserves Portion	Total Project
	in 000's				
Project Dollars		41,429	59,800	286,589	461,009
Board Designated Assets	1,989,671	2.08%	3.01%	14.40%	23.17%
Equity	3,997,791	1.04%	1.50%	7.17%	11.53%
Total Assets	6,792,940	0.61%	0.88%	4.22%	6.79%

*the data is from a report on the Providence Health & Services website and the application and addendums

The latest un-audited financial report is dated September 30, 2006. The corporation merged with Providence Services and renamed itself in January 1, 2006. The board designated cash and investment reserves as of September 30, 2006 are listed as $1.989 billion which is enough to cover the planned cash reserves use. [Source: OHPDS, Analysis pg. 3]

The OHPDS analysis states that because the CN capital expenditure for this project is part of a much larger project and that the entire project budget is financed by the parent corporation that this project would not adversely impact reserves, total assets, total liability and equity of Providence Everett Medical Center. [Source: OHPDS, Analysis pg. 4]

OHPDS also reviewed various ratios' that can give a snapshot of the financial health of Providence Everett Medical Center as of December 31, 2005. Also detailed are the first five years of the with project hospital. State 2005 ratios are included as a comparison and are calculated from all community hospitals in Washington State whose fiscal year ended in 2005. The data is collected by the Washington State Dept. of Health Hospital and Patient Data section of the Center for Health Statistics. Below is a table showing the

results. The A means it is better if the number is above the State number and B means it is better if the number is below the state number. [Source: OHPDS, Analysis pg. 4]

Table 7
Financial Ratio Scores

Providence Everett Ratio Category	Trend	State05	PEMC05	2010 CONy1	2011 CONy2	2012 CONy3	2013 CONy4	2014 CONy5	2015 CONy6
Long Term Debt to Equity	B	0.564	1.220	0.480	0.454	0.422	0.388	0.352	0.316
Current Assets/Current Liabilities	A	2.049	1.733	4.780	5.317	5.722	6.097	6.931	7.703
Assets Funded by Liabilities	B	0.432	0.620	0.354	0.343	0.329	0.313	0.295	0.275
Operating Expense/Operating Revenue	B	0.956	0.924	0.959	0.967	0.954	0.944	0.935	0.927
Debt Service Coverage	A	4.774	3.737	1.670	1.828	1.973	2.120	2.269	2.420

Long Term Debt to Equity	Long Term Debt/Equity
Current Assets/Current Liabilities	Current Assets/Current Liabilities
Assets Funded by Liabilities	Current Liabilities+Long term Debt/Assets
Operating Expense/Operating Revenue	Operating Expense/Operating Revenue
Debt Service Coverage	Net Profit+Depr and Interest Exp/Current Mat. LTD and Interest Exp

As shown, 2014 fiscal year end ratios (CON year 5) for Providence Everett Medical Center are better than the State average or are within appropriate range of the state 2005 figures except for Debt Service coverage. The debt service coverage is acceptable because of the strength of the assets of the parent corporation. [Source: OHPDS, Analysis pg. 4]

OHPDS used various documents the hospital provided in the application and the 2005 year end balance sheet and income statement as required to be reported to the Washington State Department of Health as well as Providence Health and Services un-audited financial reports from their website. Review of the financial and utilization information show that the immediate capital expenditure, long-range capital, reserves and "cash from operations" can be met.

Based on the information reviewed, the department concluded this sub-criterion is met.

(2) The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.

According to the OHPDS analysis, the costs of the project are the costs and charges the patients and community are billed for. Providence Everett Medical Center rates are below:

Table 8
PEMC Rate Comparison

Providence Everett	2010	2011	2012	2013	2014
Rate per Various Items	**CONyr1**	**CONyr2**	**CONyr3**	**CONyr4**	**CONyr5**
Patients	27,008	27,844	28,707	29,596	30,510
Patient Days	107,220	110,539	113,968	117,497	121,124
Gross Revenue	1,168,248	1,211,579	1,255,119	1,298,908	1,342,878
Deductions From Revenue	730,292	757,401	784,642	812,039	839,551
Net Patient Billing	437,956	454,178	470,477	486,869	503,327
Other Operating Revenue	15,794	16,134	16,477	16,822	17,169
Net Operating Revenue	453,750	470,312	486,954	503,691	520,496
Operating Expense	435,250	454,910	464,784	475,649	486,584
Operating Profit	18,500	15,402	22,170	28,042	33,912
Other Revenue	1,035	1,046	1,056	1,067	1,077
Net Profit	19,535	16,448	23,226	29,109	34,989
Operating Revenue per Patient	$16,800.58	$16,890.96	$16,962.90	$17,018.89	$17,059.85
Operating Expense per Patient	$16,115.60	$16,337.81	$16,190.62	$16,071.39	$15,948.34
Net Profit per Patient	$723.30	$590.72	$809.07	$983.55	$1,146.80
Operating Revenue per Patient Day	$4,231.95	$4,254.72	$4,272.73	$4,286.84	$4,297.22
Operating Expense per Patient Day	$4,059.41	$4,115.38	$4,078.20	$4,048.18	$4,017.24
Net Profit per Patient Day	$182.20	$148.80	$203.79	$247.74	$288.87
Operating Revenue per Adj Admissions	$10,563.59	$10,624.12	$10,673.76	$10,713.90	$10,745.09
Operating Expense per Adj Admissions	$10,498.32	$10,641.24	$10,544.60	$10,466.99	$10,387.66
Net Profit per Adj Admissions	$471.19	$384.75	$526.93	$640.56	$746.95
Operating Revenue per Adj Pat Days	$2,660.90	$2,676.14	$2,688.58	$2,698.69	$2,706.59
Operating Expense per Adj Pat Days	$2,644.46	$2,680.45	$2,656.04	$2,636.50	$2,616.55
Net Profit per Adj Pat Days	$118.69	$96.92	$132.73	$161.35	$188.15

Providence Everett Medical Center rates are similar to the Washington statewide averages**.** [Source: OHPDS, Analysis pg. 5]

The department concludes the project is not expected to have a remarkable impact on the cost and charges. This sub-criterion is met.

(3) The project can be appropriately financed.

The overall project will use reserves and long-term debt. OHPDS states "Providence Everett Medical Center will use reserves from its parent corporation Providence Health and Services. While not specifically addressed in the application or its addendums, the funds provided by the parent corporation are treated as an investment not a loan based on the balance sheet provided in the application. The portion of funds that the medical center will derive from bonds does show up on the medical center's balance sheet under long term debt.

While Providence Everett is committing a large amount of the hospitals assets on the overall project; to the parent corporation, Providence Health and Services, the amount is a modest percentage of their assets. The use of cash is a very appropriate and inexpensive financing method since the only constraint would be the question, is this the best use of the cash? The use of $174 million in bonds backed by the financial size of Providence Health and Services and provided through the Washington State Health

Care Facilities Authority tax exempt bond process is also very reasonable". The financing methods used are appropriate business practice. [Source: OHPDS, Analysis, pg. 5]

The department concludes, this sub-criterion is met.

C. Structured and Process of Care (WAC 246-310-230)

Based on the source information reviewed, the department determines that the application is consistent with the applicable structure and process (quality) of care criteria in WAC 246-310-230.

(1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.

PEMC projects adding 1,032.6 FTEs when this project is complete. [Source: Application pg. 37] PEMC stated the additional staff will be hired as additional beds are added. [Source: Response to Screening, June 6, 2006] Department analysis of the information has determined the following:

PEMC employed 2,274 full time equivalent staff as of December 31, 2005. PEMC employee retention rate in 2005 was 89%. PEMC also states it has a competitive wage scale and generous benefit packages and also partners with the area's educational institutions. PEMC provides a training location for these schools to allow students from various disciplines who wish to prepare themselves for a future in a healthcare related field [Source: Application, pg. 38]

The applicant maintains relationships with many of the area educational programs and has contributed funds to expand the nursing program at Everett Community College. PEMC also works with other programs to provide training sites for nurses, pharmacies, laboratory technologists and many other healthcare related disciplines.

PEMC provides tuition assistance and "Back to School" programs to employees who are interested in further certification in their existing career or pursuing a new one. On the basis of the applicant's historical ability to hire and retain qualified personnel. Efforts are also underway to improve recruitment and staff flexibility. These efforts along with the fact that the proposed project will result in the hiring to be spread out over several years are expected to assist PEMC in its staff recruitment efforts.

The department concludes that the applicant can reasonably be expected to hire personnel to staff this project. This sub-criterion is met.

(2) The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.

In response to this issue, PEMC states:

> "PEMC is an existing acute care hospital providing high quality patient services whish include appropriate ancillary and support services. The master site plan included the expansion of ancillary services to support the addition of the proposed new beds. The expanded ancillary services will ensure efficiency and access to state of the art diagnostic and therapeutic services to serve all patients in the best possible manner. Support services will be developed in proportion to

the incremental added capacity to assure cost effective implementation with a focus on quality of care". [Source: Application, pg 39]

Supporting this statement, the applicant has provided an extensive listing of the ancillary and support service agreements currently enacted at the hospital. [Source: Response to screening August 2, 2006, Attachment 6] This listing identifies 38 different service agreements ranging from, but not limited to, Transitional Care services to laboratory and staffing support. These device agreements are expected to continue or be replaced by similar types agreement if this project is approve

The department concludes that there is reasonable assurance PEMC will have appropriate ancillary and support services. Therefore, this sub-criterion is met.

(3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs.

PEMC will continue to provide Medicare and Medicaid care services to the residents of the service area. PEMC is listed by Joint Commission of Accreditation of Healthcare Organizations (JCAHO) as in full compliance with all applicable standards.[8] Within the last three years, the department's Office of Healthcare Survey conducted 3 re-licensure surveys and three rehabilitation unit surveys. One of the re-licensure surveys in 2006 resulted in a deficiency citation, but found the hospital to be in substantial compliance with applicable regulations and standards. PEMC submitted a plan of corrections in July 2006 and the report was accepted by the Office of Healthcare Survey.

The department concludes that there is reasonable assurance that the hospital would continue to operate in conformance with state and federal regulations with the addition of the requested acute care beds. This sub-criterion is met.

(4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.

PEMC stated that it encourages collaborative efforts with other healthcare provider and also stated that they are partnered with some higher instruction of learning and provided a listing with names of 25 local area educational institutions. PEMC stated that they work collaboratively with other providers to ensure access and continuity of appropriate care. The applicant also stated that Providence Hospice and Home Care of Snohomish are both part of the Providence Health System and have a close working relationship. According to the applicant, Bethany of the Northwest, a transitional care provider, is located on the PEMC Pacific Campus. PEMC stated that it's working with three unidentified major medical groups to develop an outpatient cancer care facility. Information provided by the applicant, as well as comments offered to the department by healthcare providers and consumers support these statements

The department does not expect that the proposed addition of acute care beds will have adverse effect on the collaborative relationships. The department concludes that the addition of acute care beds at PEMC will not result in an unwarranted fragmentation of services

[8] http:// www.qualitycheck.org/qualityreport.aspx?hcoid=9590

This sub-criterion is met.

(5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations.

This sub-criterion is addressed in sub-section (3) above.

D. Cost Containment (WAC 246-310-240)

Based on the source information reviewed, the department determines that the application is consistent with the applicable cost containment criteria in WAC 246-310-240.

(1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.

The applicant cites eight alternatives that were considered in addition to the project proposed. These alternatives were:

Alternative #1 – Do Nothing
Alternative #2 – Expand the Pacific Campus
Alternative #3 – Develop a new location
Alternative #4 – Expand Colby Campus to the West
Alternative #5 – Expand Colby Campus to the South
Alternative #6 – Expand Colby Campus to the North
Alternative #7 – Expand Colby Campus to the Northeast
Alternative #8 – Expand Colby Campus to the East.

These eight alternatives were rejected by PEMC in favor of the proposed project for a variety reasons. These reasons include.

- Requirement for the purchase of additional properties ranging from a city block to 30 properties.
- Displacement of home owners
- Closure of city streets
- Longer implementation time
- Higher costs and financial risk
- Greater disruptions to existing operations during construction.

The department concludes that the basis for rejecting these alternatives was reasonable. In the need section of this analysis, the department conclude that 106 bed addition rather than 166 bed addition was justified. Therefore, the best available is a 106 bed addition to PEMC. This sub-criterion is met.

(2a) In the case of a project involving construction: The costs, scope, and methods of construction and energy conservation are reasonable.

The costs of the project are the cost for construction, planning and process. Providence Everett Medical Center projections are on the following page.

Table 10
Bed Addition Cost Projections

Providence Everett	166 Beds	106 Beds
Total Capital	$ 72,824,543	$ 59,800,000
Beds/Stations/Other (Unit)	166	106
Total Capital per Unit	$ 438,702.07	$ 564,150.94

As reported by OHPDS, "the applicant notes that the capital portion of the CN project is based on the square feet the CN bed rooms will occupy and the corridors and supports space for those beds. This method is acceptable. The costs shown are within past construction costs reviewed by this office. Also construction cost can vary quite a bit due to type of construction, quality of material, custom vs. standard design, building site and other factors. Providence Everett Medical Center is building a brand new facility and will construct the new area to the latest energy and hospital standards". [Source: OHPDS Analysis, pg. 6]

The department concludes the costs, scope and methods of conclusion are reasonable. This sub-criterion is met.

(2b) <u>In the case of a project involving construction: The project will not have an unreasonable impact of the costs and charges to the public of providing services by other persons.</u>

As stated in the project description portion of this evaluation, this project involves construction. This sub-criterion is evaluated within the financial feasibility criterion under WAC 246-310-222 (C).

(3) <u>The project will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.</u>

Providence Everett Medical Center states that this project will improve system efficiency for the hospital and patient. "PEMC further states all patient rooms in the new addition will be single occupancy. In addition to offering patients increased privacy and comfort, single occupancy rooms help prevent the spread of infections between patients. Single occupancy rooms are also more efficient from operational perspectives because there is no need to find appropriate matches for patients based on age, sex, isolation requirements, etc. There, hospitals with single occupancy rooms are generally able to operate at higher occupancy rates". [Source: Application, pg. 15]

The department is aware of the benefits to the patients of single patient's rooms. The department concludes this project involves appropriate improvements in the delivery of health services. This sub-criterion is met.

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDICES